ASSEMBLY BILL 8 (NUÑEZ)
As amended July 18, 2007

PAY OR PLAY REQUIREMENTS: (effective 1/1/10)

- AB 8 would require an employer to either spend an amount equivalent to at least 7.5% of Social Security wages (capped at $97,500 in 2007) on health care or pay an equivalent amount to the new California Health Trust Fund. Employers make separate elections for full time and part-time employees.
    - According to estimates produced by Jonathon Gruber, an MIT economist, who has been producing estimates for all California health care reform proposals: 21.2 million lives would be covered by playing employers and 4.9 million by paying employers

- An employer election to pay the fee is for a two year period. This is a "pool protection" provision

- Qualifying health care expenditures that satisfy the 7.5% expenditure requirement include: contributing to a health savings account, reimbursing employees for health care expenses, establishing programs to assist employees attain and maintain health and healthy lifestyles (such as on-site health fairs and clinics), disease management programs, or buying health care coverage from a health plan or insurer.

- AB 8 would prohibit employers from attempting to avoid the requirements of law by altering or designating an employee as a contractor or temporary worker, reducing a worker's hours, or firing and rehiring a worker.

ESTABLISHMENT OF POOL FOR PAYING EMPLOYERS: (effective 1/1/10)

- Employees (and their dependents) working for employers electing to pay the 7.5% fee would receive their coverage through the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP).
    - As noted above, Gruber estimates that 4.9 million lives will be covered under the pay mechanism.
    - As noted above, employees would remain in Cal-CHIPP for at least two years.
    - If an employee were interested in subsidized coverage (see Public Coverage section below) they could, at their election, apply for it. If found eligible, they would select a Medi-Cal or Healthy Families benchmark plan offered by MRMIB (depending on family income).
        - Gruber estimates that 0.7 million of the 4.9 million lives will be unsubsidized and 4.2 million subsidized.

- Other employees/dependents who might get coverage through Cal-CHIPP:
    - If an employee working for an employer <u>providing</u> coverage were interested in subsidized coverage (see Premium Assistance section below), they could, at their election, apply for it. If found eligible, they would be covered either under a benchmark plan offered by their employer's carrier, or, if one is not offered, they would select a Medi-Cal or Healthy Families benchmark plan offered by MRMIB

(depending on family income).
    - Gruber estimates that 3.8 million lives will be covered under premium assistance. Of this number, 1.6 million are presently getting public coverage.

- Employees of paying employers are required to "take up" coverage in Cal-CHIPP unless they have other group coverage, coverage through a public program or individual coverage in effect on January 1, 2010. Dependents are not required to "take up" coverage. Employees of paying employers exempted from the take up requirement because of other coverage are allowed to purchase coverage in Cal-CHIPP
    - Employees of employers providing health care are not required to take up their employer sponsored coverage because employers do not necessarily have to provide coverage, per se.
    - .Employers are required to provide notice to their employees of the availability of subsidized coverage.

- MRMIB would offer
    - Unsubsidized Cal-CHIPP participants one of (at least) three benefit plan designs that (1) comply with Knox-Keene Act requirements plus prescription drug coverage and (2) have cost-sharing levels that promote prevention and health maintenance. The products are to have varying benefit levels, deductibles, coinsurance and annual limits on out-of-pocket expenses. [Note: Carriers are required to sell these products in the individual and group markets as well. See Insurance section below]
    - Subsidized Cal-CHIPP participants a HFP or MC benchmark plan.

- Employees and their dependents would retain eligibility in Cal-CHIPP even if their employer failed to pay the required fee.

- The Employment Development Department (EDD) would collect fees from paying employers and deposit it in the California Health Trust Fund.
    - EDD, in consultation, with MRMIB is, required to deposit funds so that they are available for timely enrollment of subscribers.
    - The bill authorizes a General Fund loan for EDD expenses occurring prior to January 1, 2011. Loan proceeds are subject to appropriation in the annual budget act.

- MRMIB responsibilities regarding Cal-CHIPP include:
    - Develop and offer the benefit plan designs for the unsubsidized and subsidized populations, including cost-sharing. Premiums for employees with a household income under 300% cannot be higher than 5% of household income.
    - Establishing subscriber participation requirements;
    - Establishing eligibility and enrollment criteria and processes;
        - Board shall consider using existing eligibility processes for determining HFP and MC eligibility, including eligibility determinations made by counties.
    - Establishing selection criteria for plans
        - The Board is required to negotiate with Medi-Cal Managed Care Plans.
    - Contracting with plans/insurers to provide coverage and negotiating rates to be paid;
    - Assisting subscribers with plan selection by providing information on plan quality and cost-effectiveness
    - Establish a workgroup that, prior to January 1, 2009, will make recommendations

to the Legislature to broaden access to Cal-CHIPP to self-employed persons;
- Adopt emergency regulations as needed to implement the program beginning January 1, 2008 to December 31, 2011.

- AB 8 would authorize MRMIB to:
  - Adjust the fee paid to Cal-CHIPP by employers by October 31st of each year
  - Adjust subscriber premiums after considering the costs of health care typically paid for by employers and employees in California.
    - However, premiums for persons with family incomes below 300 cannot exceed 5 percent of household income (after taking into consideration the tax savings realized from paying premiums through a section 125 plan (see section on 125 plan below) .

SECTION 125 PLANS

- Under Section 125 of the Internal Revenue Code, employers can allow employees to pay their portion of health insurance premiums on a pre-tax basis. AB 8 would require all employers to establish a 125 Plan.
  - Employees save money because their income for taxable purposes is reduced by the amount spent on health insurance premiums. Savings accrue from reductions in Federal Insurance Contributions Act (FICA) taxes, federal income taxes and state taxes.
    - Worker savings would range from 17.65% to over 42% of worker premium payments, depending on income and family structure.
  - Employers experience a reduction in their taxable payroll and therefore pay less in FICA taxes.
    - Employer savings would equal 7.65 of the workers' premiums paid through the section 125 plan (this is the employer's share of FICA on the amount by which taxable salary is reduced).

PUBLIC COVERAGE EXPANSIONS FOR LOW-INCOME CHILDREN AND ADULTS

CHILDREN'S COVERAGE (effective 7/1/08)

- AB 8 would expand income eligibility for the Healthy Families Program (HFP) from 250% of federal poverty level (FPL), to at or below 300% FPL, (from $42,925 for a family of three to at or below $51,500 for a family of three).

- Children in families with incomes of 250% FPL to 300% FPL would pay monthly premiums of $22 to $25 per child, up to a maximum family monthly premium of $75.

- AB 8 would establish a Medi-Cal floor at 133% of the federal poverty level (at or below $22,836 for a family of three) for all children ages 1 to 18.
  - Low income families with children of different ages may currently be split between coverage in Medi-Cal and HFP, which have different networks and cost sharing requirements.
  - Under AB 8, all children ages 1 to 18 with incomes below 133% FPL would be eligible for Medi-Cal. All children aged 1 to 18 with incomes between 133% and 300% FPL would be eligible for the HFP. Current law would not change for infants 0 to 1 (allows families with income up to 200% FPL in Medi-Cal).

- AB 8 would make full-scope Medi-Cal and HFP available to children regardless of their documentation status.

PARENTAL COVERAGE (effective 7/1/08)

- AB 8 would expand eligibility in Medi-Cal and HFP to low-income, working parents of children with family incomes between 100% (at or below $17,170 for a family of three) and 300% of FPL.

- Parents with family incomes between100% to 133% would receive coverage through an expansion of 1931(b) Medi-Cal. Parents working for a paying employer would enroll in a MC benchmark plan under Cal-CHIPP. Those with incomes between133% to 300% FPL would enroll in a HFP benchmark benefit package.

PREMIUM ASSISTANCE AND BENCHMARK PLANS (effective 7/1/08)

- AB 8 would require group health plans and insurers to either offer Medi-Cal and HFP benchmark plans in the commercial market or send persons seeking subsidized coverage to Cal-CHIPP.
    - Carriers wishing to sell the benchmarks in the commercial market would negotiate with MRMIP on the price of their product. If MRMIB approved the rate, the carrier would be responsible for collecting the employer's cost-share and credit that amount towards the cost of the benchmark plan
    - Carriers wishing to send subsidized persons to Cal-CHIPP would collect the employer's cost-share for Medi-Cal or HFP-eligible enrollees and dependents and send it to MRMIB to offset costs of coverage.

- Carriers are required to notify employees of the availability of subsidized coverage in their evidence of coverage documents.

INSURANCE MARKET REFORMS

Individual Market Reforms (effective 7/1/08)

- MRMIB would develop a list of medical conditions to determine a person's eligibility for MRMIP. The purpose of the list is to identify the 3% to 5% of people who are the most expensive to treat.
    - MRMIB would design a health status questionnaire which carriers would have applicants fill out to identify persons with the list of conditions established above. While there is no explicit date by which these activities must be done, they have to be completed prior to the 7/1/08 provision immediately below.

- Carriers would have to sell coverage on a guaranteed issue basis to any person that does not have one of the conditions on the list. Any person that does have such a condition will be referred to the high risk pool. These persons are "automatically eligible" for MRMIP. Effective 7/1/08

- The regulators will jointly establish 5 classes of benefits that carriers must guarantee issue and renew. Effective 1/1/10.
    - Each class shall reflect a reasonable continuum between the class with the

lowest and highest benefits with each class having an increased level of benefits.
    - Each class shall have one baseline HMO and one PPO.
    - The regulators must assure that the plans provide for reasonable benefit variation.

- Subscribers can change classes of benefits, as follows:
    - During the month of birth, the subscriber can change one level up.
    - Movement to a lower class can be at any time.
    - After a significant life event, (such as divorce, death of spouse, adoption), subscriber may move up to a higher class.

- Rate variance is allowed for age, family size and geographic regions, (all as determined by the regulators). Carriers are also allowed to provide health improvement discounts.

Mid-Size Employer Market Reforms (effective 7/1/08)

- AB 8 would extend protections to mid-size employers (51 – 250 employees), currently given to small employers (2 – 50 employees). Specifically, plans/insurers selling coverage to mid-size employers would be required to guarantee issue all health insurance products, publish rates, and enact rate bands to limit the variation in premiums charged. Currently, a 10% variation is allowed for rates charged to small and mid-sized employers compared with those filed with the Department of Insurance and the Department of Managed Health Care. These rate bands would be phased out in both small and mid-sized group markets. The phasing out of rate bands would occur at least three months before enrollment in the purchasing pool, Cal-CHIPP, begins (see page 3).

Uniform Benefit Design

- AB 8 would require the MRMIB to develop and offer at least three uniform benefit plans designs within Cal-CHIPP, with varying benefit levels, deductibles, coinsurance and annual limits on out-of-pocket expenses.

- AB 8 would require plans/insurers to sell these uniform benefit plan designs in all individual and group markets where the plan provides services.

Minimum Medical Loss Ratios (effective 7/1/08)

- Currently, health plans under DMHC regulations must not spend an "excessive amount" on administrative costs in any fiscal year while the DOI Commissioner must withdraw approval of individual policies if he/she finds that the benefits provided are unreasonable in relation to the premium charged. The requirement to withdraw individual policies does not apply to group policies regulated by DOI.

- AB 8 would require the Department of Managed Health Care (DMHC) and the Department of Insurance (DOI) to each adopt a regulation requiring at least 85% of health plan and insurer revenue be spent on health care services, referred to as a "medical loss ratio." The requirement applies across all markets.

- AB 8 would require plans and insurers to disclose to all prospective purchasers, instead of only to individuals and groups of 25 or fewer employees as currently required, the medical loss ratio.

COST CONTAINMENT

- Preventive services. All of the state-developed uniform benefit designs will include coverage for primary and preventive care with minimal patient cost sharing, including essential medications that allow patients to cost-effectively manage their chronic conditions, such as asthma, diabetes and heart disease.

- Disease Management. The California Health and Human Services Agency would lead the effort to review and develop best practice standards. Every state health coverage program, including the California Public Employees Retirement System (Cal-PERS), Medi-Cal, Healthy Families, and Cal-CHIPP, will implement best practices in treating high cost chronic diseases, such as asthma and diabetes.

- Pay for Performance. The California Health and Human Services Agency will take the lead in creating a common Pay for Performance model in every health coverage program receiving state dollars.

ENROLLMENT SIMPLIFICATION (effective 7/1/08)

- Under current law, in order to be eligible for 1931(b) Medi-Cal coverage, a family's countable property cannot exceed certain dollar thresholds depending upon the number of people in the family. AB 8 would expand the 1931(b) program to low-income working adults that will have assets, such as savings accounts, and eliminate the asset test to expand coverage. It would eliminate the requirement that certain adult Medi-Cal beneficiaries file a semiannual status report, but still require beneficiaries to submit an annual reaffirmation indicating their ongoing eligibility for the program.

EVALUATION (effective 1/1/08)

- AB 8 would require the California Health and Human Services Agency (HHSA) to contract with a nonprofit group, foundation, academic institution or governmental entity to track and assess the effects of health care reform and the sustainability of Cal-CHIP.

- A five-member advisory body with legislative and gubernatorial appointments would guide the assessment and, with HHSA would establish a timeline for reporting data annually to the Legislature, including data about employer compliance and cost of health coverage in the state.

- The assessment would include, for example, the number of people receiving coverage through the purchasing pool, the cost and affordability of health care, the quality of health care services, the change in access and availability of health care throughout the state, and the impact of reforms on employers, employment, employer-based health coverage, and the county health care system, including uncompensated care and emergency-room use.